



COLLEGE of
NURSING

EAST TENNESSEE STATE UNIVERSITY

East Tennessee State University
College of Nursing
P.O. Box 70403
Johnson City, TN 37614
(423) 439-4077

Office of Practice & Community Health Center

Hancock County School-Based Clinics
P.O. Box 723
Sneedville, TN 37869
(423) 733-2819

Johnson City Community Health Center
2151 Century Lane
Johnson City, TN 37604
(423) 926-2500

SECTION I		PATIENT INFORMATION	
Last Name		First Name	
SSN		Date of Birth	
Address		City State Zip Code	
Home Phone ()		Cell Phone ()	
E-Mail		Work Phone ()	
Emergency Contact Name		Contact Preference [] Ok to leave confidential messages [] Don't leave confidential messages	
Emergency Contact Number ()		Relationship to Patient	
Mother's Maiden Name (used for identification purposes only)			
Language Spoken (mark all that apply) [] English [] Spanish [] Other _____		Marital Status [] Single [] Married [] Widowed [] Divorced	
Student Status [] Full Time [] Part Time [] Not a Student			
Homeless Status [] Not Homeless [] Doubling up [] Shelter [] Street [] Transitional [] Other _____			
Migrant\Seasonal Status [] Migrant (A person\dependent whose principle employment has been in agriculture within the last 24 months and has had to establish a temporary home for the purpose of such employment) [] Seasonal (A person\dependent whose principle employment has been in agriculture on a seasonal basis and has not had to establish a temporary home for the purpose of such employment) [] Not a Farm Worker			
Interpreter Status [] YES [] NO		Housing Status [] Public Housing [] Not in public housing	
Race [] Asian [] American Indian [] Black\African-American [] Native-Hawaiian [] More than one race [] White [] Other Pacific Islander [] Other _____		Ethnicity [] Hispanic or Latino [] Not Hispanic or Latino	
Veteran Status [] YES [] NO [] N/A		Referred By [] Relative\Friend [] Church [] Health Fair [] Hospital [] Newspaper [] Other _____	
Do you have an Advance Directive? [] YES [] NO			

SECTION II		RESPONSIBLE PARTY INFORMATION	
Skip if different from Section I			
RELATIONSHIP TO PATIENT <input type="checkbox"/> Self (skip to next section <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Last Name	First Name	Middle Name	
SSN	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (if different from above)	City	State	Zip Code
Home Phone ()	Cell Phone ()	Work Phone ()	
Employer	Employer Name	Employer Phone ()	
SECTION III		INCOME INFORMATION	
Total household income last month: \$	Total persons living in household last month		
<input type="checkbox"/> Decline to provide household income			
OFFICE USE ONLY			
Qualify for sliding fee discounts? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> 100% & below <input type="checkbox"/> 101-133% <input type="checkbox"/> 134-175% <input type="checkbox"/> 176-200%			
SECTION IV		INSURANCE INFORMATION	
Please present all insurance information			
PRIMARY INSURANCE			
<input type="checkbox"/> No Insurance <input type="checkbox"/> Medicaid\TennCare <input type="checkbox"/> Medicare <input type="checkbox"/> Other (Employer\Private\Commercial)			
PATIENTS RELATIONSHIP TO INSURED PARTY			
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			
Plan Name	Policy Number	Group Number	
Insured Name	Insured SSN	Insured Date of Birth	
Effective Date (if known)	Co-Pay \$		
Employer	Employer Address	Employer Phone ()	
SECONDARY OR DENTAL INSURANCE			
<input type="checkbox"/> Medicaid\TennCare <input type="checkbox"/> Medicare <input type="checkbox"/> Other (Employer\Private\Commercial)			
PATIENTS RELATIONSHIP TO INSURED PARTY			
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			
Plan Name	Policy Number	Group Number	
INSURED NAME	Insured SSN	Insured Date of Birth	
Effective Date (if known)	Co-Pay \$		
Employer	Employer Address	Employer Phone ()	



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PATIENT FINANCIAL & INSURANCE AGREEMENT **PLEASE READ THOROUGHLY AND SIGN BELOW**

In consideration of receiving services from the ETSU College of Nursing, Community Health Centers, you agree:

1. All services are provided to you with the understanding that you are responsible for the charges regardless of your insurance coverage. If you would like to know the charge of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**
2. At check-in, we will collect your co-pay, deductible, and payment for uncovered services as well as the patient's portion as determined by insurance or sliding fee scale. We accept cash, check, and credit card of Master Card, Visa, and Discover.
3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. **It is the patient's responsibility to inform our office immediately of insurance coverage or insurance company changes.**
4. You are responsible for knowing if a referral is required. Make sure you know what providers are in your plan, what facilities are covered and what ancillary services you must use. (Such as laboratory, hospitals, etc.) If we can be of assistance, please let us know.
5. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance company to question why the claim is not paid. Our office will assist you only after you have contacted your insurance company.
6. If your medical claim has not been paid and your insurance company has not resolved your dispute, you may register a complaint with the Tennessee Department of Commerce and Insurance. Our office will do everything we can to assist you; however, you must understand you cannot delay payment while you are awaiting the outcome of your complaint.
7. Any unpaid charges over 90 days old will be sent to an outside collection agency with an additional agency fee. **You are responsible for any collection fees, legal fees, or court costs incurred in the collection process.** This agency will report your failure to pay to the THREE (3) national credit reporting agencies.
8. Returned checks are subject to a \$40.00 return check fee.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I authorize the East Tennessee State University (ETSU) College of Nursing (CON) Community Health Center (CHC) to examine, evaluate, and treat me, and/or my child, or ward. I authorize the CHC to release any/all clinical information necessary in order to submit my insurance claims to my insurance companies. I also request that my insurance companies pay benefits directly to the CHC for services rendered. I understand that the CHC will refund any overpayments on my account, in a timely manner.

Your signature below forms a binding agreement between the CHC (the provider of service) and the Patient who is receiving services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of any charges

Patient Printed Name

Patient/Guardian Signature

Date

CHC Staff Signature

Date

